

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-027677

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 75 Primary Registration District No. 3015 Registrar's No. 68

FILED JUL 17 1963

1. PLACE OF DEATH a. COUNTY <u>CLINTON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>CLINTON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CAMERON</u>		c. CITY OR TOWN <u>Camerton</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Cameron Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>716 W. 4th St.</u>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Bickel Ellwood</u>			4. DATE OF DEATH Month Day Year <u>July 12, 1963</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10-29-1886</u>	9. AGE (last birthday) <u>76</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>
11. BIRTHPLACE (City and state or country) <u>LATHROP MO</u>			12. CITIZEN OF WHAT COUNTRY. <u>USA</u>		
13a. FATHER'S NAME <u>HENRY ELLWOOD</u>		13b. MOTHER'S MAIDEN NAME <u>LAURA BICKEL</u>		14. NAME OF HUSBAND OR WIFE <u>Artie Ellwood</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mrs. Artie Ellwood, CAMERON MO</u>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Cecum</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		
DUE TO (b)		
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>June 9, 1963</u> to <u>July 12, 1963</u> and last saw him alive on <u>July 12, 1963</u> Death occurred at <u>2:40 p.m.</u> on the date stated above, and to the best of my knowledge from the causes stated.			
22a. SIGNATURE <u>J.D. Kuyner M.D.</u>		22b. ADDRESS <u>Camerton MO</u>	
22c. DATE SIGNED <u>7-13-63</u>			

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>7/15.63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Graceland Cemetery CAMERON MO.</u>	23d. LOCATION (City, town, or county) (State) <u>MO.</u>
24. FUNERAL DIRECTOR <u>DeMoss SPRUNK. CAMERON, MO</u>		25. DATE RECD. BY LOCAL REG. <u>July 15 1963</u>	
26. REGISTRAR'S SIGNATURE <u>Francis V. Crawford</u>			

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

VS 300  
Rev. 4/59

1 0251  
2 0251  
3  
4 0  
5 2  
6  
7 0  
8 2  
9 153.0  
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11  
12 1-0  
13 2-0

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*[Handwritten Signature]*

Licensed Embalmer No. 2533

P.O. Address COMERON, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.